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ABSTRACT

Efforts to foster mental health care in society have always been hampered by the stigma attached to mental illness. To identify differential patterns of attitude hierarchies among people who live in or provide mental health services in a typical urban area, 54 adults participated in a Q methodology study of their attitudes toward mental illness. The subjects were 18 to 55 years of age and over, and had educational backgrounds from non-high school degrees to college graduates; 26 were community mental health center professionals from the Toledo, Ohio area. In a stepwise progression subjects sorted statement cards into rank order patterns (Q sorts) which were then factor analyzed into clusters of persons (Q types) according to the correlates of their card sorting behavior. These new empirically derived models were then compared with theoretical models held by mental health professionals. An analysis of the results identified two archetypal models of opinion held by two different age groups: pessimistic egalitarians and optimistic environmentalists. Pessimistic egalitarians were found to be significantly younger and more accepting of a medical model of mental illness, in which all races and classes are presumed to be equally at risk. Optimistic environmentalists tended to tie mental illness to socio-cultural problems such as poverty and discrimination. The egalitarians were also much more likely than the environmentalists to believe that most people hold a stereotypical view of the mentally ill as dirty, dangerous, and unpredictable; the environmentalists were more hopeful about the attitudes of their fellow man. The findings point out the complexities in the task of educating the community for involvement and support for community mental health programs. (Tables presenting residents' and professionals' Q sorts and Q types are appended.) (Author/BL)

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A Qualitative Study of Attitudes Toward Mental Illness: Implications for Public Education

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--Abstract--

A STUDY OF ATTITUDES TOWARD MENTAL ILLNESS: A Q-METHODOLOGICAL APPROACH*

By James H. Bissland, Ph.D., and Richard Munger, Ph.D.

Numerous studies of public attitudes toward mental illness and the mentally ill have produced contradictory and confusing results. The present study, conducted in Toledo, Ohio, in 1980, is one of the first attempts to deliberately seek to identify differential patterns of attitude hierarchies among people who live or provide mental health services in a typical urban area. The study employed Stephenson's Q-methodology, in which subjects sort decks of statement cards into rank-order patterns ("Q sorts"), and are then factor-analyzed into clusters of persons ("Q types") according to the correlations of their card-sorting behavior. These new empirically derived models can then be compared with the theoretical models held by professionals. In the Toledo study, two archetypal models of opinion, held by different age groups, were identified among the 80 subjects tested individually or in small groups in sessions averaging one hour, 42 mins., each: Pessismistic Egalitarians and Optimistic Environmentalists. Pessismistic Egalitarians were found to be significantly younger and more accepting of a "medical model" of mental illness, in which all races and classes are presumed to be equally at risk, than were Optimistic Environmentalists who tended to tie mental illness to socio-cultural problems of poverty, discrimination, etc. The Egalitarians were also much more likely than the Environmentalists to pessimistically believe that "most people" hold a sterotypical view of the mentally ill as dirty, dangerous and unpredictable; the Environmentalists were more hopeful about the attitudes of their fellow man. If mirrored in the general population, these belief systems have profound implications for public education efforts, to date and in the future.

*Presented at the Annual Meeting of the American Psychological Association, Anaheim, CA, August, 1983.

Efforts to foster mental health care in society have always been hampered by the stigma attached to mental illness. The community mental health movement has accentuated and in some ways aggravated the problem. First, deinstitutionalization and the return of much of the responsibility for mental health care to the grassroots has forced to local community into direct confrontation with problems it used to be able to export. Second, many of the philosophical tenets of the community mental health movement--prevention, environmental change, fostering of natural support systems and so on--have outstripped the public attitudes needed to facilitate them.

In a sense, therefore, the community mental health movement may have "gone public" before the public was ready for it--and more significantly, before the mental health professionals have acquired the technical skills needed to influence public attitudes. The problem has been further compounded by the growth of the Proposition 13 mentality and the culture of privatism. As a result, a priority must now be placed on developing better means of communicating on behalf of mental health, means that will help reduce stigma, increase citizen participation, and sustain the community movement in general.

The President's Commission on Mental Health (1978) described some of the costs of lack of public understanding and support: the difficulties the mentally ill and handicapped face in their home communities after hospital discharge; the fact that many who need help do not seek it, and those who have received it will not admit it; the inadequate funding of mental health services; and the fact that mental illness "tends to distrub and repel people" (Vol. I, p. 56). instead of evoking sympathy. Others have observed the problems in public attitudes toward mental illness, too. For example, Mechanic (1969)

succinctly contrasted the striking difference in attitudes toward physical and mental illness. Langsley (1975) noted that "mental health treatment methods and institutions are held in relatively law esteem" (p. 58).

Similarly, the President's commission Task Panel on Public Attitudes rhetorically asked in the 1978 report "whether the mental health professionals have exercised to the fullest their responsibility regarding greater public understanding of mental health and illness" (Vol. IV, p. 1868). It was clear the panel did not think the professions had, but it also appeared that the panel felt the research tools and knowledge available to the professions were not adequate to the task:

> New methods for measuring community and individual attitudes must be devised; otherwise it will be impossible to assess the impact different community facilities have on individuals and neighborhoods; learn why people have certain feelings about those with mental illness and emotional problems; and to learn how to develop a greater acceptance of mental patients and mental health services. (Vol. I, p. 56).

RESEARCH PROBLEM

The empirical study of public attitudes toward mental illness has been dominated by the traditional large-sample survey that employs conventional instrumentation--primarily independent scales--to gain normative data. Typical examples include Nunnally's (1961) survey of 400 persons in the 1950's, Bentz and Edgerton's (1971) survey of 14,000 predominantly rural respondents in the south, and so one. While other research designs can be found, there generally has been much less interest in conducting research that is in depth instead of

breadth, that is ipsative or person-centered, that has a strong qualitative flavor, and that is as useful for its heuristic as its normative outcomes.

As a result, there has been relatively little data developed that describes the structural qualities of public attitudes, i.e., the hierarchical organization of interdependent ideas toward an object of orientation. There also has been little done in the psychographic segmentation of the public--i.e., the classifying of people according to their attitude structures. And yet it is obvious that such information could be valuable in targeting audiences for public education programs. All successful efforts to communicate and persuade must begin (if they are going to rely on more than luck) by understanding the meanings subjects hold for relevant stimuli. The research problem to which this project was addressed, therefore, was the crucial need of mental health professionals to develop deeper understandings of the differential meanings people in their communities ascribe to mental illness and mental health services. It is important that these understandings derive from psychologically richer data than traditional social surveys can now provide. If possible, they should be related to behavior, and in any case, they should be sensitive enough to detect significant modifications in the shape of public attitudes before and after communication interventions.

A research approach that could address itself to these needs but has been little utilized in the study of public attitudes toward mental illness is Q methodology--a general name used by William Stephenson to characterize a set of philosophical, psychological, statistical, and psychometric ideas oriented to research on the individual (Kerlinger, 1973). Among other things Q methodology is distinguished by its identifying of correlations between <u>persons</u> and the

creation of factors composed of people in contrast to more traditional correlational procedure ("R methodology") which uses correlations between tests. It is especially suitable for studying complex attitudes. As Brown and Ungs (1972) observed "Q-methodology appears to provide a way to model the subjective aspects of attitudes that does not appear to be available through survey research." Accordingly, the research described in this paper employed such a methodology.

METHODOLOGY

Development and the Q Instrument

Development of the Q set of statements, the major instrument used in the study, required six steps. The first step was development of a pool of semantic possibilities--"all the things that could be said"--on the subject of mental illness. A total of 1,000 such statements was developed from a variety of sources, including semi-structured interviews with a quota sample of 30 area residents; a lengthy questionnaire administered to 12 members of the staff of a community mental health center; and a survey of popular, professional, and scholarly literature on attitudes toward mental illness, including the major studies conducted by Nunnally (1961), Cohen and Struening (1962), Elinson, Padilla and Perkins (1967), and Askenasy (1974).

The second step was a conservative culling out of the most obvious duplicates, irrelevancies and unclear items, reducing the pool to 450 items. Next, a review of the literature indicated that the various research thrusts developed over the years on the subject of public attitudes toward mental illness had touched on a total of 10 major dimensions or conceptual categories: definitional issues, perceptions of external behavior, and questions of prevalence, etiology, social problems, stigma, treatment, social policy, epidemiology, and impairment related to mental illness. Accordingly, a three-member panel was asked to sort

the 450 statements into these 10 categories, reducing the population to 291 statements on which the three judges were unanimous.

Further reduction was necessary, however. Accordingly, four new panelists, all scholars or practitioners familiar with community mental health, independently selected those items they judged potentially most useful for a Q research instrument. Based on their choices, comments and recommendations, the authors then wrote a draft set of 60 items in a "balanced block" design. In this design, the Q set was partitioned into 10 conceptual categories, with three pairs of items written for each category. Each pair was so written as to represent polar opposites of position on one dimension of meaning. The draft set was then independently critiqued by three consultants--two clinical psychologists and a researcher who specializes in Q methodology--and a final set of 60 items written according to their recommendations. This revised set was printed, one item to a card, for use as the major instrument in the study. (A complete list of the items can be found in any of the typal arrays, Tables 1 or 2).

The Research Package

The research procredure employed in the study was actually a package of eight main parts, requiring 10 steps for the subject to complete. The eight parts were:

1. Q sort of statements cards for "self;"
2. Open-ended explanation of polar choices for "self;"
3. Test of satisfaction with procedure;
4. Q sort of statement cards for "most people;"
5. Open-ended explanation of polar choices for "most people;"
6. Estimates of prevalence of mental illness;
7. Vignettes to test recognition of mental illness;
8. Confirmation of demographics.

In addition, Parts 1 and 4, the Q sorts, were performed by the subject in two steps: a pre- or rough sorting of the cards into three roughly equivalent piles, followed by a more refined forced sorting into a 2-3-4-7-9-10-9-7-4-3-2 pattern (a slightly flattened normal curve) based on an 11-point scale ranging from "strongly agree" to "strongly disagree." In part 1, subjects were asked to sort the cards so as to describe themselves; in Part 4, to sort them as they believed "most people" would sort them.

The other six parts of the package were auxiliary tests designed to obtain supplementary information. For example, Parts 2 and 5 simply were open-ended opportunities for subjects to explain their polar sorting choices, that is, the two statements each had assigned to each of the two extreme columns. The test of satisfaction, Part 3, was administered immediately after the Self sort as a partial means of checking the validity of the methodology.

In Part 6, subjects were asked to estimate the prevalence of mental illness in the community to see if there was any relationship between such estimates and the various Q types. Another procedure to test for additional differences between Q types involved asking subjects to take a vignette test (Part 7). The use of vignettes, or short hypothetical case histories, has a long history in measuring public recognition and denial of mental illness, and stems from the pioneering work of Shirley Star (Joint Commission on Mental Illness and Health, 1961).

The questions in Part 8 simply confirmed each subject's eligibility to be in the quota sample, which had been constructed with membership balanced according to age, education, race and sex.

The amount of time subjects required to complete the research package was recorded in 52 of the 80 cases. Times ranged from 50 minutes to 3 hours, 15

minutes, with the average for both the resident and staff groups being an identical 1 hour, 42 minutes.

Sampling Procedure

The study sampled two populations: the residents of one regional catchment area in an Ohio city, a service district encompassing twenty-seven census tracts and an estimated 110,000 persons, and the staff members of that catchment area's community mental health center (CMHC): an agency of more than 60 mental health professionals.

This catchment area was chosen from the four which comprised the metropolitan area because its population is a heterogenuous cross-section of the major racial and socio-economic groups typical of many cities and their nearby suburbs.

A multistage process was used to obtain a quota sample of 54 residents. In the first stage, 1,227 households were identified by a strictly random sampling process. Each household was sent a personally addressed envelope containing a printed flyer, cover letter, response form, and postpaid reply envelope. Without indicating that the specific topic was mental health, the materials invited residents "to earn $10 and help your comminity by giving us your opinion on health issues in the area." A repeat mailing was sent approximately three weeks later.

A total of 167 households, or 13.6% of the original pool, responded affirmatively. Because research literature suggests that age and education levels influence attitudes toward mental illness, a quota sample of 54 residents was constructed from this pool according to a modified three-by-three matrix, in which three levels of age (18 to 34, 35 to 54, 55 and over) defined one

axis, and three levels of education (non-high school graduate, high school graduate, college graduate) defined the other. Equal proportions of persons were obtained for each age level, but a short supply of non-high school graduates in the sample pool necessitated a disproportionate distribution among the three educational levels: 8 non-high school graduates, 30 high school graduates, and 16 college graduates. The sample of residents included almost equal proportions of males and females; three quarters of the sample members were white, one fourth were black. For clarity of results, all other minorities were excluded.

A total of 26 CMHC staff members also participated in the study. Sample membership was limited to professional (college graduate) staff members involved in service delivery or its direct administration at the CMHC. Within these guidelines, a convenience sample of 9 holders of bachelor's degrees, 15 with master's degrees, and 2 with Ph.D.'s was obtained.

Data Analysis

Data gathered from the two card sorts performed by each subject were computer processed by Van Tubergen's QUANAL, a Q factor analysis program. Factor analysis employed the principal axis method. Solutions were chosen by the criterion of Cattell's Scree Test.

RESULTS

The mental health professions have long built their theoretical models from psychological theories and research on the nature of mental illness itself. By contrast, this study was an attempt--perhaps the first of its kind--to create empirically based models of the perceptions of mental illness held by the people who live or provide mental health services in a typical urban service area.

The study employed Q methodology for its power to find and differentiate various patterns of hierarchical attitude structures that may exist in a population. Characteristically, however, Q must be used with small samples and appreciated more for its heuristic than its normative capabilities. More research is needed to determine the extent to which the findings of this study may prevail in larger populations. Nevertheless, data from the 80 subjects tested in the study suggest the following:

First, most residents in the sample share a common body of conventional wisdom on which they prefer to draw in describing themselves via the "self" sort. For example, among the strongest preferences of residents are statements of entitlement ("Everyone has a right to mental health care . . .), faith in mental health professionals, and recognition of the complexity, universality and reality of mental illness. At the same time, however, most residents decline to take strong positions either affirming OR rejecting statements that impugn the predictability, moral character, and harmlessness of the mentally ill.

Second, beyond their points of agreement, however, residents are classifiable into five different patterns of "self" description, of which the two major ones are what might be called the "Egalitarians" (Type I) and the "Environmentalists" (Type IV) (Table 1). Egalitarians are notable for their confidence in the democracy of epidemiology and the irrelevancy of gender, ethnicity and economic level to mental illness. By contrast, Environmentalists are must surer that environmental factors are important in epidemiology.

Third, the same residents are also classifiable into three different patterns of opinions about how they think "most people" regard mental illness (Table 1). Of these, the two major ones are the "Optimists," (Type I) who see other

people primarily as being benevolent, in their attitudes toward mental illness (Type II) and the "Pessimists," who tend to be significantly younger and who see most other people as matching the classic stereotype of negativism toward mental illness which typically holds the mentally ill to be dirty, dangerous and unpredictable.

Fourth, to more specifically identify principal patterns of card-sorting behavior by participants in the study, the authors developed the concept of "megatypes" (Table 3). Megatypes are created by the crosstabulation of "self" and "most people" data. Thus defined by both "self" and "most" test behavior, each megatype represents the sum of 120 card-sorting decisions by a group of people, instead of 60. No less than 67 percent of the resident sample in the study are clustered into only four such megatypes (Megatypes 1, 4, 6, 9), although there is a theoretical maximum of 15 megatype possibilities. These four key combinations can be called: "pessimistic egalitarians" (Megatype 1); "optimistic egalitarians" (Megatype 6); "pessimistic environmentalists" (Megatype 4); "optimistic environmentalists" (Megatype 9).

Fifth, organizing these four megatypes into their own matrix of four cells results in two pairs of conceptual opposites on each of the diagonals: pessimistic egalitarians vs. optmistic environmentalists on one diagonal, and optimistic egalitarians vs. pessimistic envornmentalists on the other. But two additional steps need to take place before the reduction process is complete. First, the Pearson r self/most people intercorrelations of -.42 and .71 are the most extremely opposite or distant on that diagonal formed by Megatypes 1 and 9, the pessimistic egalitarians and the optimistic environmentalists. In other words, Megatype 1 people both draw a very dark picture of how they believe "most people" view mental illness AND insist that view is very different from

their own, while Megatype 9 people are far more optimistic about the benevolence of "most people" and, moreover, describe themselves as being somewhat like "most people" in their attitudes. Second, t-tests comparing, in turn, each one of the four largest megatypes described here with all 14 remaining megatypes as an aggregate show that only megatypes 1 and 9 differ significantly from the rest of the population on any demographic. That demographic is age. Specifically, with nearly two-thirds of its members in the 18-34 age bracket, Megatype 1 is significantly younger, on the average, than the rest of the resident sample ($t=-2.49$, $p < .05$), while Megatype 9, with two-thirds of its members age 55 and over (and none 34 or under!) is significantly older than the rest of the resident sample.

Sixth, CMHC staff members cannot be so easily reduced to archetypes, but they can clearly be seen to prefer to describe themselves in three different ways, two of which are primarily psychosocial in character, and one which has more of a medical model flavor to it and which correlates very highly with the position of the "Egalitarians" (Tables 2, 4). All staffers hold negative images of how most people view mental illness: their three types of such images differ only in emphasis, not direction.

Seventh, all CMHC staff members and many residents fail to accurately predict how "most people" would sort the statement cards. Indeed, the description residents and CMHC staff members provide for themselves correlate far more with each other (from .43 to .94 for major types) than do CMHC staff predictions for "most people," which correlate as negatively as -.62 with the way some residents actually describe themselves.

Eighth, neither estimates of prevalence nor tests of recognition of mental illness via vignettes in the Star tradition appear to clearly differentiate

residents from CMHC staff members nor, in most cases, attitudinal types from each other. Only the demographic of age differed significantly between certain types.

Ninth, all parts of the Q methodology procedure were shown by two different tests (test-retest and split sample) to be highly reliable (Pearson r scores ranged from .85 to .96). In addition, 96 percent of residents and 92 percent of staffers in the study expressed satisfaction with their ability to express themselves via the procedures.

IMPLICATIONS FOR PUBLIC EDUCATION

In recent years, concern about public attitudes has been spurred by the community mental health movement, with its emphasis on deinstitutionalizing the mentally ill in favor of community-based treatment and natural support systems. A clash of unresolved public interests regarding the impact of locating small home care facilities in residential neighborhoods for the treatment of persons formerly in large-scale institutions has become increasingly felt in local communities and in neighborhoods across the country. Rothman (1980) notes that people may be sympathetic to the problems of the mentally ill in theory, but they do not want them wandering in their neighborhoods. The growing need for public acceptance and support of the mentally ill has necessitated a concomitant need for public education.

The stigma people attach to mental illness has been documented since at least the early 1950's (Rabkin, 1972, 1974, 1975, 1977), but there has been sharp disagreement over just what effect deinstitutionalization and public education may have had on modifying negative public attitudes in recent years. Those researchers who view mental illness from the perspective of traditional

psychiatry report they are encouraged by what they see as growing public acceptance of a medical or "disease" model of mental illness. But other researchers, working from a psychosocial or transactional understanding of mental illness, see members of the public as still widely fearful and ignorant about mental illness. They not only doubt the appropriateness of teaching the public a medical model perspective, but deride efforts on its behalf as a "failed moral enterprise" (Sarbin & Mancuso, 1970).

The data from this study suggests the possibility that younger generations may be learning a body of preferred statements that de-emphasizes the social factors in the epidemiology of mental illness in favor of an egalitarianism that may be superficially appealing but not based on fact. Contrary to much popular and CMHC staff opinion, for example, research has demonstrated that matters of gender, economic condition and ethnicity do play a role, for fultural reasons, in the epidemiology of mental illness. Denying this can have serious implications for public policy. So also can a pessimistic view that "most people" have far more negative opinions about mental illness than they may actually have. And yet these are the understandings apparently shared both by younger residents and many CMHC staff members. And yet the disagreements continue between advocates of the medical model and those supporting a psychosocial view of mental illness.

A recent report of the American Medical Association (1979) concluded that the abandonment of the medical model has led to role confusion on the part of most community mental health centers. Many centers, the report says, classify their services as "mental health" even when the bulk of services are not aimed at mentally ill "patients" but at "clients" with problems of living. The report contends that this concentration or nonmedical concerns contradicts the intent

of the CMHC legislation. The findings were based on a review of the literature and on first-hand experience in centers of six advisory panelists.

Conversely, a recent Institute for Social Research (1980) study of this nation's mental health policies drew different conclusions from its scientific national sample. The IRS researchers concluded that the failure to achieve the goals of the CMHC's Act has created a need for redefinition. They believe that the source of that redefinition may be a link between mental health and quality of life: "The two approaches are radically different. The medical model focuses largely on individual pathology and looks to psychotropic drugs for solutions. The quality of life approach examines the broader range of social life, with a view to maximizing prevention and treatment. It focuses on the problems of ordinary people who encounter situations that cause mental problems" (Institute for Social Research, 1980, p. 5).

Nieburh (1980) argues that the American socialization systems are failing and the aggregate sense and vitality of "community" are in disarray. He maintains that advocates of the deinstitutionalization strategy need to assist the citizenry to gain the understanding of quality of life, and only then, will we have humane and vital neighborhoods to house and accept our clients. He proposes that public education focus on the broader issue of the socialization process, as opposed to remedial and therapeutic intervention.

Rabkin's (1974) review demonstrated convincingly the public's growing acceptance of the tenets of a medical position. Sarbin and Mancuso (1972), however, seriously question the propagandizing of a model that easily can mislead the general public to unwarranted conclusions about the origin of certain human behaviors. Mancuso (1980) holds that there is little to be gained from trying to remove the public's negative view of mental illness. Instead he advocates changing the concept of mental illness to a more psychosocial image.

Although the present study suggests the possibility that the public is increasingly accepting basic propositions of the medical paradigm, the time has come to present alternative paradigms (Office of Prevention, 1979). No research evidence has been presented that suggests that campaigns to gain public acceptance of the medical model have brought positive benefits to the attitude holder. Evidence indicates that there is some utility in offering the public non-medical, psychosocial paragigms. Research studies convincingly demonstrate that "demythologizing" seminars are effective in changing the general public's attitudes toward mental illness (Morrison & Teta, 1977). In small seminars, each of the myths of mental illness is considered with ample opportunity for discussion and disagreement. The implications of these studies are important. If changing the public's attitudes in the direction of a psychosocial approach leads to such positive effects as more positive self-attributions, then perhaps one can tentatively conclude that the public finds "psychological relief" in construing psychological problems in psychosocial as opposed to medical terms (Morrison, 1979) . Further, it has been proposed that "demythologising" offers a method of preparing a community or neighborhood for patients discharged from mental hospitals (Morrison, 1980).

Finally, to the list of stereotypes long acknowledged by those who work in mental health must be added this study's finding of the negative way many people characterize OTHER people's view of mental illness. In this study, many, though not all, community residents and all mental health professionals said they regarded "most people" as highly fearful, biased and ignorant on the subject. But such findings raise major questions: Just what effect does it have on people's behavior regarding a subject like mental illness to believe that most other people are so negative about it? How does such a pessimistic view

influence the work of mental health professionals? In particular, are such beliefs dysfunctional for communication work, such as public education, carried on for mental health?

To the extent that mental health professionals are experts in their field, they tend to be victims of "trained incapacity;" that is, they may be highly knowledgeable about mental health therapy and service delivery while not sufficiently understanding the forces of public opinion and community attitudes that surround their activities. By its nature, the community mental health movement has raised consciousnesses about the social systems within which mental health professionals must work. But being conscious of those systems and knowing how to plan and employ interventions on behalf of mental health are two different things. In short, mental health professionals must acquire the understandings and tools required to secure the kind of community involvement and support that will help them carry out their programs. This study has demonstrated the complexities of their task.

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TABLE 1
RESIDENTS' TYPAL ARRAY OF ITEM Z SCORES,
UNDER TWO CONDITIONS OF INSTRUCTION

Items	Q types and z Scores							
	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
n:	(24)	(2)	(3)	(17)	(8)	(25)	(20)	(9)
Var.[a]:	(23.6)	(6.0)	(4.7)	(15.0)	(9.4)	(21.0)	(15.0)	(7.9)
1. Most people go through their lives without having some kind of mental illness.	-0.1	1.2[b]	-0.1	-0.5	0.1	0.9	0.6	0.2
2. The mentally ill let themselves get dirty and sloppy.	-0.6	-0.4	0.3	-0.4	-1.3[c]	0.9	-0.3	-0.3
3. There are many different reasons for mental illness.	1.9[b]	0.8	1.7	1.7	1.5	0.0	2.1[b]	0.1
4. Mentally ill people tend to be bad neighbors.	-0.5	-1.4[c]	-0.4	-0.8	-0.7	1.2[b]	0.1	0.2
5. There is usually something about mentally ill people that makes it easy to tell they're that way.	-0.8	-0.3	1.2[b]	0.2	-1.6[c]	1.0[b]	0.2	0.6
6. People who are mentally ill are apt to be dangerous.	-0.7	-0.1	0.6	0.1	-1.6[c]	1.9[b]	0.1	0.3
7. The use of things like medicines and specialists like doctors will make the biggest difference in getting better for most mentally ill people.	0.2	0.1	1.8[b]	0.9	1.7	0.6	1.4[b]	1.2

(RESIDENTS' TYPAL ARRAY, PAGE 2)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
8. Poor people have more mental illness than people with money.	-1.8	-0.3	-1.8[c]	-1.1	-1.4	1.0[b]	-1.5[c]	0.5
9. There is a growing number of mentally ill people in Toledo and Maumee.	0.2	0.3	0.2	0.5	-0.6	-0.4	0.2	1.4[b]
10. "Mental illness" is nothing more than a term people use to describe behavior that's very odd or unacceptable.	-0.9	1.2	0.8	-1.4[c]	1.1	0.6	-0.7	0.0
11. A person should be sent for professional help as soon as there seems to be a possibility they are mentally ill.	0.9	-0.2	1.7	1.8[b]	1.7	-0.1	1.7[b]	0.9
12. Mentally ill people themselves are often responsible for their becoming that way.	-1.1	-1.2[c]	-0.0	-1.0	-1.0	0.9	-1.3[c]	0.7
13. There is more mental illness among women than among men.	-1.0	-0.3	-1.9[c]	-0.2	-1.0	0.0	-1.2[c]	0.1
14. Mental illness is not a widespread problem in Toledo and Maumee.	-0.5	0.9	-0.3	-1.2[c]	-0.5	0.7	-0.2	-1.0
15. You can't really count on mental health specialists, like doctors and counselors, to be much help to the mentally ill.	-1.3	-2.1[c]	0.3	-2.0	-1.0	-0.6	-1.7	-2.3[c]
16. Ex-mental patients must be managed with special care by their employers if they are to succeed.	-0.1	-0.4	0.4	0.3	0.2	0.4	-0.2	0.3

(RESIDENTS' TYPAL ARRAY, PAGE 3)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
17. Most people in Toledo and Maumee who need mental health care get it.	-0.9	0.5	-0.5	-0.9	0.4	0.5	-0.2	-2.1[c]
18. The different races and ethnic groups in Toledo and Maumee are all just as apt to experience mental illness.	0.9[b]	0.6	0.5	0.7	0.6	-0.6	0.8	0.5
19. Most people with mental illness should put themselves in the hands of professionals, and depend on them to find a cure.	0.2	0.8	0.3	1.2[b]	0.8	0.9[c]	1.1	2.0[b]
20. People who are being treated for mental illness should live at home in Toledo and Maumee, instead of mental hospitals, as much as possible.	0.7	-1.4[c]	-0.7	0.1	-0.2	-1.7[c]	-0.5	-0.2
21. The meaning of the term "mental illness" is clear.	-1.6[c]	-0.8	-0.9	-0.3	-0.5	-0.3	-2.1[c]	-0.5
22. Services to the mentally ill in Toledo and Maumee deserve more of our tax money than they're getting now.	0.9	-0.1	1.6[b]	1.0	-0.3	-1.7[c]	-0.5	0.6
23. Toledo and Maumee face many other problems that are more serious than mental illness.	-0.3	1.1[b]	-0.8	-0.7	0.0	1.2[b]	0.3	-0.0
24. Mentally ill people can usually tell right from wrong.	-0.1	-0.7	-1.3[c]	-0.1	-0.1	-1.3[c]	-0.7	-0.8

(RESIDENTS' TYPAL ARRAY, PAGE 4)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
25. People who have been mentally ill never quite recover from it.	-1.0[c]	-0.6	0.6	-1.0	-0.5	1.4[b]	-0.8	0.2
26. You never know what a mentally ill person will do next.	-0.1	-0.2	1.0[b]	0.1	0.0	1.6[b]	0.7	-0.1
27. Everyone has a right to mental health care, regardless of his ability to pay for it.	(2.3)[b]	(1.9)	(1.8)	(2.0)	(1.5)	0.0	1.2	1.3[b]
28. In general, most mental health specialists--such as doctors and counselors--can help mentally ill people get over their problems.	(0.9)	(1.0)	(1.1)	(1.8)[b]	(1.2)	0.2	1.5	1.9[b]
29. Most mental illness is caused by the same kind of thing.	-1.3	-0.1	-1.0	-1.1	-2.0[c]	-0.1	-1.6[c]	-0.5
30. It usually doesn't harm a neighborhood to have someone with a mental illness living in it.	0.8	0.8	1.0[b]	0.2	0.7	-1.6[c]	-0.6	-1.4
31. Most mental illnesses have physical or medical causes.	-0.2	-0.8	0.7	0.6	0.7	-0.2	0.4	0.7
32. Homosexuals are not necessarily mentally ill.	1.0	-1.4[c]	-0.8	-0.2	-1.0	-0.7	0.2	-1.0
33. Wealth or poverty doesn't affect the amount of mental illness people have.	1.5[b]	-0.2	0.5	-0.5	1.1	-0.8	1.5[b]	-0.1

(RESIDENTS' TYPAL ARRAY, PAGE 5)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
34. The problem of mental illness can be found throughout Toledo and Maumee.	(1.5)[b]	(1.0)	(0.5)	(1.0)	(1.4)	0.5	1.5[b]	1.0
35. It's not the government's job to make sure that mental health services are available to everyone who needs them.	-1.4	-1.9[c]	-0.8	-1.0	-0.4	-0.0	-0.8	-0.2
36. You wouldn't mind people knowing if a member of your family was being treated for mental illness.	0.9	0.0	0.9	0.9	0.1	-2.2[c]	-0.1	-1.6
37. Mental illness strikes men just as much as it does women.	1.0[b]	0.6	0.4	0.4	0.9	-0.2	0.6	-0.3
38. Too many of our tax dollars are being spent on services to the mentally ill in Maumee and Toledo.	-1.4	-1.2	-2.2[c]	-1.4	-0.5	1.0[b]	-0.8	-1.3[c]
39. If they really tried, most people could get over mental illness without professional help.	-1.3	-1.6	-1.2	-1.6[c]	-0.4	0.2	-1.8[c]	-1.4
40. One can usually predict how a mentally ill person will behave.	-0.8	-0.7	-0.8	-0.5	-1.9[c]	-0.3	-1.1[c]	-0.8
41. Mental illness is one of the most serious problems in Toledo and Maumee.	0.1	-2.2[c]	1.2[b]	0.2	-0.6	-1.2[c]	-0.0	0.8

(RESIDENTS' TYPAL ARRAY, PAGE 6)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
42. It's hard to say just what "mental illness" is.	1.4[b]	0.2	0.3	-0.1	0.2	0.1	2.1[b]	-0.6
43. There are many people in Toledo and Maumee who need mental health services, but aren't getting them.	1.1[b]	-0.2	1.0	0.8	-0.0	-0.4	0.3	2.4[b]
44. You can't blame mentally ill people themselves for their becoming that way.	1.1[b]	0.8	0.2	0.8	0.0	-0.5	0.9	0.4
45. Mentally ill people do not pose a threat to the safety of a community.	0.3	0.9	0.0	-0.2	-0.2	-1.9[c]	-0.6	-1.4
46. Some races and ethnic groups in Toledo and Maumee have more mental illness than others.	-0.5	-0.3	-2.2[c]	0.2	-0.2	0.6	-0.6	-0.6
47. Mentally ill people often have poor moral standards.	-0.6	0.0	-0.7	-0.5	-1.3[c]	1.2[b]	-0.2	-0.3
48. The number of people in Toledo and Maumee who are mentally ill is probably about the same as it's always been.	-0.2	1.9[b]	-0.7	-1.0	0.2	-0.0	-0.2	-1.1[c]
49. People who are mentally ill usually take good care of their clothes and cleanliness.	-0.1	0.4	-1.1[c]	-0.9	-0.9	-1.3[c]	-0.6	-0.9

(RESIDENTS' TYPAL ARRAY, PAGE 7)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
50. For most mentally ill people, the care and encouragement of the people around them, like families, friends, neighbors & employers, will make the biggest difference in their getting better.	1.6	1.7	1.0[c]	1.9	2.2[b]	-0.5	1.5[b]	0.7
51. It would be embarassing to have someone in your family under treatment for mental illness.	-1.0	-1.0	-0.0	-1.4[c]	0.5	1.7[b]	-0.4	0.1
52. The best place for people who are being treated for mental illness is usually in mental hospitals.	-1.1[c]	1.4[b]	0.7	0.0	-1.0	2.0[b]	0.5	1.1
53. Mental illness is a real illness, like any other.	2.1	1.1	-0.1	2.1	2.2[b]	-0.9	1.9[b]	0.1
54. Homosexuality or being "gay" is mental illness.	-0.9	0.2	-0.7	-0.3	0.1	0.9	-0.5	0.6
55. Mental illness is primarily caused by social factors, such as the stresses of modern life or the way people are treated by other people.	0.3	-0.7	-0.2	1.6[b]	0.7	-0.0	0.5	2.4[b]
56. Bosses should expect ex-mental patients to take the same responsibilities as other employees.	0.2	-0.3	-1.7[c]	-0.4	-0.3	-0.5	-0.1	-0.8
57. People can recover completely from mental illness.	0.6	1.0	-0.5	1.1[b]	0.7	-1.5[c]	-0.1	-0.7

(RESIDENTS' TYPAL ARRAY, PAGE 8)

	"Self"					"Most People"		
	I	II	III	IV	V	I	II	III
58. At one time or another, most people have some kind of mental illness.	0.3	-1.6[c]	-1.0	0.3	1.1[c]	-1.1[c]	-0.5	-0.2
59. Unless you're around them a lot, it's usually hard to know if people are mentally ill.	0.3	1.5[b]	0.4	0.1	0.3	-1.2[c]	-0.3	-0.4
60. You should not seek professional help for someone until you are very sure they are mentally ill.	-0.8	0.9	0.2	-1.4[c]	-1.2	-0.3	-1.2[c]	-0.3

[a]% of total variance accounted for.
[b]Discriminator item: z score ≥ 1.0 and greater than all other types.
[c]Discriminator item: z score ≥ 1.0 and smaller than all other types.
()Consensus item: all intertypal differences < 1.0 z.

TABLE 2
CMHC STAFF MEMBERS' TYPAL ARRAY OF ITEM Z SCORES,
UNDER TWO CONDITIONS OF INSTRUCTION

Items	Q types and z Scores					
	"Self"			"Most People"		
	I	II	III	I	II	III
n:	(10)	(12)	(4)	(11)	(9)	(6)
Var.[a]:	(22.2)	(26.3)	(12.6)	(42.6)	(8.0)	(4.3)
1. Most people go through their lives without having some kind of mental illness.	-0.6	-0.8	-0.5	0.6	0.1	0.1
2. The mentally ill let themselves get dirty and sloppy.	-0.5	-0.3	0.0	0.9	0.5	0.8
3. There are many different reasons for mental illness.	(1.3)	(1.8)[b]	(1.8)	0.3	0.7	0.2
4. Mentally ill people tend to be bad neighbors.	-0.9	-0.9	-0.7	0.9	0.6	2.1[b]
5. There is usually something about mentally ill people that makes it easy to tell they're that way.	-0.4	-0.5	-0.1	1.4[b]	0.1	0.7
6. People who are mentally ill are apt to be dangerous.	-1.3[c]	-0.8	-0.1	(1.5)[b]	(1.0)[c]	(1.4)
7. The use of things like medicines and specialists like doctors will make the biggest difference in getting better for most mentally ill people.	-1.2[c]	-0.1	0.1	0.6	1.7	0.0
8. Poor people have more mental illness than people with money.	0.3	-1.3[c]	1.2[b]	-0.6	0.5	0.4
9. There is a growing number of mentally ill people in Toledo and Maumee.	0.3	0.4	0.5	-0.6	0.5	0.4
10. "Mental illness" is nothing more than a term people use to describe behavior that's very odd or unacceptable.	0.8	-0.7	-0.2	-0.3	-0.0	0.3

(CMHC STAFF MEMBERS' TYPAL ARRAY, PAGE 2)

	"Self"			"Most People"		
	I	II	III	I	II	III
11. A person should be sent for professional help as soon as there seems to be a possibility they are mentally ill.	-0.1	1.1[b]	0.8	-1.4[c]	0.1	0.2
12. Mentally ill people themselves are often responsible for their becoming that way.	0.5	-0.9	-1.3[c]	0.7	-0.4	1.6[b]
13. There is more mental illness among women than among men.	-0.4	-0.8	0.0	0.3	-0.2	0.1
14. Mental illness is not a widespread problem in Toledo and Maumee.	(-0.7)	(-1.3)[c]	(-1.3)	1.0	-0.1	0.1
15. You can't really count on mental health specialists, like doctors and counselors, to be much help to the mentally ill.	(-1.4)[c]	(-1.2)	(-1.2)	-0.2	-1.5[c]	-0.3
16. Ex-mental patients must be managed with special care by their employers if they are to succeed.	-0.4	0.0	-0.1	0.4	0.4	-0.4
17. Most people in Toledo and Maumee who need mental health care get it.	-0.6	-1.1[c]	-0.9	0.9	-0.7	0.5
18. The different races and ethnic groups in Toledo and Maumee are all just as apt to experience mental illness.	0.7	1.0[b]	-0.4	0.6	-0.8	-0.9
19. Most people with mental illness should put themselves in the hands of professionals, and depend on them to find a cure.	-1.4[c]	0.1	-0.4	-0.5	2.2[b]	1.0
20. People who are being treated for mental illness should live at home in Toledo and Maumee, instead of mental hospitals, as much as possible.	(1.7)[b]	(1.1)	(1.1)[c]	(-1.3)	(-1.5)[c]	(-1.1)[b]

(CMHC STAFF MEMBERS' TYPAL ARRAY, PAGE 3)

	"Self"			"Most People"		
	I	II	III	I	II	III
21. The meaning of the term "mental illness" is clear.	-1.7[c]	-1.4	-0.4	-1.0	-1.6[c]	0.6
22. Services to the mentally ill in Toledo and Maumee deserve more of our tax money than they're getting now.	(0.5)	(1.0)	(1.3)[c]	(-1.3)	(-1.2)[c]	(-1.7)[c]
23. Toledo and Maumee face many other problems that are more serious than mental illness.	-0.3	-0.4	-0.5	(1.5)[b]	(0.9)	(1.0)
24. Mentally ill people can usually tell right from wrong.	1.0	0.6	1.1[c]	0.0	-0.4	-1.6[c]
25. People who have been mentally ill never quite recover from it.	-1.2[c]	-0.7	-0.3	(1.3)[c]	(1.5)[b]	(1.4)
26. You never know what a mentally ill person will do next.	-0.5	-0.4	-0.9	(1.7)[b]	(0.9)	(1.2)
27. Everyone has a right to mental health care, regardless of his ability to pay for it.	(1.4)[c]	(1.9)	(2.1)[b]	-0.2	0.9	-1.0
28. In general, most mental health specialists--such as doctors and counselors--can help mentally ill people get over their problems.	0.5	0.7	0.5	-0.9	1.4[b]	-0.0
29. Most mental illness is caused by the same kind of thing.	-1.1[c]	-0.9	-0.6	-0.3	-0.5	0.3
30. It usually doesn't harm a neighborhood to have someone with a mental illness living in it.	(1.3)[b]	(0.9)	(0.9)	(-1.1)[b]	(-1.6)[c]	(-1.3)
31. Most mental illnesses have physical or medical causes.	-1.1[c]	-0.7	-0.3	-0.2	0.5	0.1
32. Homosexuals are not necessarily mentally ill.	(1.4)[b]	(1.0)	(0.8)	(-1.6)[c]	(-1.3)	(-1.0)[b]

(CMHC STAFF MEMBERS' TYPAL ARRAY, PAGE 4)

	"Self"			"Most People"		
	I	II	III	I	II	III
33. Wealth or poverty doesn't affect the amount of mental illness people have.	-0.6	1.6[b]	-1.7[c]	0.6	-0.5	-1.5[c]
34. The problem of mental illness can be found throughout Toledo and Maumee.	(1.1)	(1.4)[b]	(1.2)	0.1	0.9	-0.4
35. It's not the government's job to make sure that mental health services are available to everyone who needs them.	(-1.2)[b]	(-1.3)	(-1.7)[c]	0.2	-1.2[c]	-0.0
36. You wouldn't mind people knowing if a member of your family was being treated for mental illness.	0.3	0.8	-0.7	(2.0)	(-1.5)[b]	(-1.8)
37. Mental illness strikes men just as much as it does women.	0.3	1.2[b]	0.1	-0.4	-0.1	0.1
38. Too many of our tax dollars are being spent on services to the mentally ill in Maumee and Toledo.	(-0.7)	(-1.5)[c]	(-1.2)	0.8	0.5	1.3[b]
39. If they really tried, most people could get over mental illness without professional help.	-0.5	-1.2[c]	-1.2	2.1[b]	-1.3[c]	0.4
40. One can usually predict how a mentally ill person will behave.	-0.5	-0.3	-0.2	-1.6[c]	-1.0	0.8
41. Mental illness is one of the most serious problems in Toledo and Maumee.	0.2	0.6	0.8	-1.7[c]	-0.8	-0.5
42. It's hard to say just what "mental illness" is.	1.8[b]	1.1	0.3	0.5	1.4[b]	-0.6
43. There are many people in Toledo and Maumee who need mental health services, but aren't getting them.	(0.8)	(1.3)[b]	(0.8)	-0.3	-0.0	-0.5
44. You can't blame mentally ill people themselves for their becoming that way.	-0.2	1.1	1.1[c]	-0.8	-0.1	-0.9

(CMHC STAFF MEMBERS' TYPAL ARRAY, PAGE 5)

	"Self"			"Most People"		
	I	II	III	I	II	III
45. Mentally ill people do not pose a threat to the safety of a community.	1.2[b]	0.7	-0.2	-1.1[b]	-1.6	-2.5[c]
46. Some races and ethnic groups in Toledo and Maumee have more mental illness than others.	0.3	-0.6	0.9	0.3	0.4	1.0
47. Mentally ill people often have poor moral standards.	(-1.1)	(-0.8)	(-1.6)[c]	0.5	0.6	1.8[b]
48. The number of people in Toledo and Maumee who are mentally ill is probably about the same as it's always been.	-0.1	-0.5	-0.3	0.1	-0.2	-0.0
49. People who are mentally ill usually take good care of their clothes and cleanliness.	-0.1	-0.1	-0.7	-0.9	-1.0[c]	-0.9
50. For most mentally ill people, the care and encouragement of the people around them, like families, friends, neighbors & employers, will make the biggest difference in their getting better.	2.5[b]	1.7	1.3[c]	0.3	1.1[b]	0.1
51. It would be embarassing to have someone in your family under treatment for mental illness.	-0.2	-1.1[c]	-0.1	1.4	1.6	0.4
52. The best place for people who are being treated for mental illness is usually in mental hospitals.	(-1.8)[c]	(-1.5)	(-1.4)[b]	(0.9)	(1.3)	(1.9)[b]
53. Mental illness is a real illness, like any other.	-0.6	1.8[b]	1.7	-1.2[c]	0.8	-0.3
54. Homosexuality or being "gay" is mental illness.	(-1.5)[c]	(-0.9)	(-1.2)	(1.0)[c]	(1.2)[b]	(1.2)

(CMHC STAFF MEMBERS' TYPAL ARRAY, PAGE 6)

	"Self"			"Most People"		
	I	II	III	I	II	III
55. Mental illness is primarily caused by social factors, such as the stresses of modern life or the way people are treated by other people.	1.2	0.0	1.8	0.2	0.7	-0.6
56. Bosses should expect ex-mental patients to take the same responsibilities as other employees.	0.8	0.2	0.1	-1.4[c]	-0.6	-0.1
57. People can recover completely from mental illness.	1.7[b]	0.6	0.1	(-1.5)	(-1.8)[c]	(-1.3)
58. At one time or another, most people have some kind of mental illness.	(1.3)	(0.9)	(1.5)[b]	(0.8)	(-1.4)	(-1.5)[c]
59. Unless you're around them a lot, it's usually hard to know if people are mentally ill.	0.4	-0.1	0.4	-0.4	-0.1	-0.9
60. You should not seek professional help for someone until you are very sure they are mentally ill.	-0.8	-1.4	-2.1[c]	1.7[b]	0.2	0.8

[a]% of total variance accounted for.
[b]Discriminator item: z score ≥ 1.0 and greater than all other types.
[c]Discriminator item: z score ≥ 1.0 and smaller than all other types.
()Consensus item: all intertypal differences < 1.0 z.

TABLE 3
CROSSTABULATION OF RESIDENTS' Q TYPES

	"Self" Type 1	"Self" Type 2	"Self" Type 3	"Self" Type 4	"Self" Type 5	Row Totals
"Most" Type 1	(Megatype 1)	(Megatype 2)	(Megatype 3)	(Megatype 4)	(Megatype 5)	
	Residents: 14	Residents: 1	Residents: 0	Residents: 7	Residents: 3	Total: 25
	Pearson r -.42 p=.000	Pearson r .07 p=.290	Pearson r .02 p=.434	Pearson r -.19 p=.079	Pearson r -.14 p=.151	
"Most" Type 2	(Megatype 6)	(Megatype 7)	(Megatype 8)	(Megatype 9)	(Megatype 10)	
	Residents: 9	Residents: 0	Residents: 1	Residents: 6	Residents: 4	Total: 20
	Pearson r .77 p=.000	Pearson r .52 p=.000	Pearson r .55 p=.000	Pearson r .71 p=.000	Pearson r .71 p=.000	
"Most" Type 3	(Megatype 11)	(Megatype 12)	(Megatype 13)	(Megatype 14)	(Megatype 15)	
	Residents: 1	Residents: 1	Residents: 2	Residents: 4	Residents: 1	Total: 9
	Pearson r .33 p=.005	Pearson r .24 p=.030	Pearson r .46 p=.000	Pearson r .56 p=.000	Pearson r .27 p=.020	
Column Totals	Total: 24	Total: 2	Total: 3	Total: 17	Total: 8	Total: 54

TABLE 4
CROSSTABULATION OF CMHC STAFF Q TYPES

	"Self" Type 1	"Self" Type 2	"Self" Type 3	Row Totals
"Most" Type 1	(Megatype 1)	(Megatype 2)	(Megatype 3)	
	CMHC staff: 5	CMHC staff: 5	CMHC staff: 1	Total: 11
	Pearson r -.47 p=.000	Pearson r -.60 p=.000	Pearson r -.46 p=.000	
"Most" Type 1	(Megatype 4)	(Megatype 5)	(Megatype 6)	
	CMHC staff: 5	CMHC staff: 3	CMHC staff: 1	Total: 9
	Pearson r -.33 p=.005	Pearson r -.23 p=.038	Pearson r -.02 p=.434	
"Most" Type 3	(Megatype 7)	(Megatype 8)	(Megatype 9)	
	CMHC staff: 0	CMHC staff: 4	CMHC staff: 2	Total: 6
	Pearson r -.65 p=.000	Pearson r -.69 p=.000	Pearson r -.49 p=.000	
Column Totals	Total: 10	Total: 12	Total: 4	Total: 26